

POLICY BLUEPRINT

INTRODUCTION

The key to fixing the health care system is value-based care, grounded in market-based strategies such as appropriate financial incentives, healthy competition, transparency and consumer engagement.

Short of curing diseases outright, value-based care provides the greatest opportunity to curb health care costs and improve care at the scale and pace we need to revitalize the economy and invest in other national priorities.

Ultimately, a value-based health care system will result in **improved clinical outcomes and better health** for all Americans, as well as **lower costs to consumers, employers and taxpayers**. Furthermore, these changes will improve productivity, enable increased wage growth, and contribute to the competitiveness of U.S. businesses in the global marketplace.

We must work together as private and public purchasers to:

- **Break down barriers for private sector innovation**

Systemic barriers exist that prevent health care markets from being effective and delivering valuable, innovative products at affordable costs. The intentions and efforts of patients, purchasers and providers to operate under the market-based principles of free and informed choice and competition will continue to be inhibited absent government action.

- **Use our purchasing power to spur change**

The federal government is the largest single purchaser of health care; much can be done through the leadership of the Health and Human Services Department, Centers for Medicare and Medicaid Services, the Federal Employee Health Benefits Program, Department of Defense health programs, the Veterans Administration, and the Indian Health Service.

Through the DRIVE Health Initiative, as America's largest private health care purchasers, we have committed to working together and with government leaders at all levels to advance value-based care.

VALUE-BASED CARE REQUIREMENTS

1. Transparent Information

To be informed consumers, individuals and employers must have information about cost, quality and outcomes to determine which health plans, providers and services deliver the best value for their needs. Health care providers also need information to benchmark performance across local markets and engage in quality improvement activities.

2. Meaningful Outcome Measures

Meaningful standardized measures of clinical outcomes (e.g., what percentage of patients died within 30 days after heart surgery?), patient-reported outcomes (e.g., did your pain decrease after treatment?), and patient experience (e.g., did your provider listen carefully to you and treat you with respect?) must be publicly available for all health care providers, patients, plans and purchasers.

3. Meaningful Choices

Patients must be given meaningful choices and be free to choose among high-value providers, services and plans that work best for them, based on commonly available performance measures that effectively compare providers, procedures and pharmaceuticals. This includes price information for high priority conditions and services such as surgery and chronic disease management.

4. Appropriate Financial Incentives

Providers must be rewarded for delivering the best outcomes, rather than a discrete set of services. Patients also must have financial incentives to use high-value providers and services.

5. Freedom to Practice and be Rewarded under Innovative Payment Models

Providers must be free to practice medicine in ways that serve the best interest of patients. This requires regulatory relief that allows innovative practice designs, smart incentives that reward outcomes rather than procedures, and simplifying reporting requirements by standardizing performance measures across all payers.

6. Proactive Public and Private Alignment

New provider payment models and performance reporting must be accelerated and harmonized across public and private payers, lowering the administrative burden on health care providers and amplifying the impact of incentives.

POLICY RECOMMENDATIONS

Government leadership as a legislator, regulator and purchaser of health care can dramatically accelerate value-based care.

REGULATORY ACTION

We urge you to accelerate the move toward value-based care by rapidly advancing these regulatory changes—reforms that do not require congressional action.

1. Regulations implementing the Medicare Access and CHIP Reauthorization Act (MACRA) and other existing laws should include the following key elements:
 - Strong financial incentives for **hospitals to provide high-quality care**, including reduction of avoidable readmissions and hospital-acquired conditions.
 - Strong financial incentives for **physicians to provide high-quality care**.
 - Definitions of **alternative payment models** to support full accountability and meaningful financial incentives for quality, patient experience and total cost of care.
 - An explicit timeline to incorporate **prospectively-set payments for comprehensive bundles** (facility, professional and drugs) in all CMS episode-based payment programs.
 - CMS has proposed a delay of the Episode Payment Model (for joint replacements and leg fractures) and the Cardiac Rehabilitation program. They were originally scheduled to be implemented in July 2017, and should move forward without delay.
 - Requirements for **public reporting of meaningful and useful performance measures**, as well as funding for the rapid development and testing of new measures to fill existing gaps.
 - Under current public programs, reporting patient reported outcomes (PROs) is voluntary. We urge you to require all Medicare alternative payment models to include meaningful and useful **publicly reported measures of clinical outcomes, PROs and patient experience**.
2. Federal health care programs must continue to partner in value-promoting efforts.

Although some have expressed opposition to the current design of the Centers for Medicare and Medicaid Innovation (CMMI) bundled payment programs, we urge continued support for innovative value-based models. CMMI (or a similar organization with authority to **test and spread innovative provider payment and care delivery models**) and the State Innovations Model program should remain fully funded and operational, and should partner with other payers when possible.

CONGRESSIONAL ACTION

The administration should support legislation that advances value-based care including consumer engagement and financial incentives, alternative payment models, and transparency and performance measures.

1. Consumer Engagement and Financial Incentives

- Modify requirements for use of **Health Savings Account (HSA) Eligible High-Deductible Health Plans (HDHPs) to allow first-dollar coverage** for costs up front that will tend to improve health and reduce outlays later.
 - Rationale: Currently, HSA-eligible HDHPs can only pay first-dollar coverage for certain “preventive services” or, put another way, the HDHP cannot pay for some high-value medical services, such as eye exams for diabetes patients and other chronic care management services before the patient has met their deductible—a counterproductive result.
- Enable chronically ill Medicare beneficiaries to have **lower cost sharing for high-value Chronic Care Management (CCM) services**. Providers accepting upside and downside financial risk should be permitted to reduce or waive patient cost-sharing (including co-pays, co-insurance and deductibles) for high-value CCM services.
 - Rationale: Currently, providers are not allowed to waive cost-sharing requirements for services needed by chronic care patients, which may cause some beneficiaries not to obtain needed services, and to incur greater health risks and costs later.
- Allow Medicare Advantage plans more flexibility to experiment with **Value-Based Insurance Design (VBID)** for patients with chronic conditions.
 - Rationale: Currently, Medicare Advantage plans are not allowed to tailor benefits for specific patient groups, such as those with chronic conditions.

2. Alternative Payment Models

- Incorporate **larger financial incentives** for providers taking on two-sided performance risk under all federal alternative payment models, including those under MACRA.
 - Rationale: Under the existing MACRA law, incentive payments for Merit-based Incentive Payment System (MIPS) are limited to +/- 4% in 2021, moving to +/- 9% in 2022 and beyond. In MACRA Alternative Payment Models (APMs), providers must bear “more than nominal financial risk,” generally considered to be at least 4%.
- Include an **opt-in approach for the Medicare Accountable Care Organization (ACO)** program that may include enhanced benefits for engaged beneficiaries.
 - Rationale: Medicare beneficiaries are “attributed” to ACOs based on past patterns of provider visits. As a result, these consumers are often unaware of their participation in the ACO and are not engaged in managing their care.
- Re-examine and relax the limitations on the use of **telehealth** services in Medicare for providers accepting accountability for quality, patient experience, and total cost of care.
 - Rationale: Medicare payment for telehealth services is severely limited, thereby discouraging more cost-effective diagnosis and treatment in accountable care models.

3. Transparency and Performance Measures

- Support the creation of aggregated **databases that pool data from various sources**, including clinical data from providers and hospitals as well as insurance claims data, to provide information regarding aspects of quality, efficiency, and price. Data collection and reporting standards and processes should be harmonized across states to minimize the administrative costs of data reporting for providers and insurers.
 - Rationale: Currently, most state and regional data aggregators rely on voluntary submission of claims data from health plans, and clinical data is seldom collected. Furthermore, data collection and reporting processes vary by state, which makes it administratively costly for national health plans to participate.
- Ensure health plan enrollees (including those in the Federal Exchanges and Federal Employee Health Benefits Program) have meaningful and useful **quality information and price calculators** that include plan- and provider-specific total costs and expected out-of-pocket costs for common inpatient and outpatient procedures and conditions.
- Reinforce and accelerate **interoperability** requirements for electronic medical records and patient-generated data. Strengthen incentives for providers to demonstrate meaningful use of interoperable EHRs under MACRA.

The DRIVE Health Initiative was launched by the Pacific Business Group on Health and The ERISA Industry Committee – organizations representing America’s largest employers – to champion and accelerate the transition to a value-based health care system. If you would like more information about DRIVE Health Initiative or if you are a policymaker and would like to discuss any of these ideas, please contact drivehealth@pbgh.org or jgelfand@eric.org.